STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

29 HAZEN DRIVE, CONCORD, NH 03301-6504
603-271-4741 1-800-852-3345 Ext. 4741
Fax: 603-271-4506 TDD Access: 1-800-735-2964

John A. Stephen
Commissioner

Mary Ann Cooney
Director

Conrad 30 J-1 Visa Waiver Semi Annual Report
(Due January and July of each year)

Please make copies for future use:

Evaluation Date: _____

Physician Name: _____ Specialty: _____

Current Address: _____ Home Ph: _____

Employment Start Date: _____ Annual Salary: _____

Evaluation Time: From: _____ To: _____

Employer Name: _____

Address: _____

Contact Person: _____ Phone: _____

E-mail: _____ Fax: _____

Please check one:
□ HPSA □ MUA □ MUP □ Non-HPSA □ DHPSA □ MHPSA

Practice Type:
- ❑ CHC
- ❑ FQHC/CMHC
- ❑ Private Practice
- ❑ Hospital Clinic
- ❑ Group Practice
- ❑ Hospital
- ❑ Other (Specify)_____

Enter daily office hours (include admininistrative time, do not include time spent on call)

Day		Time (Start and End)	Day		Time (Start and End0
Monday	AM:	PM:	Tuesday	AM:	PM:
Wednesday			Thursday		
Friday			Saturday		
Sunday					

Additional Practice Location (only if located in another county)_____

Average hours worked per week at healthcare facility: _____

Number of total patient visits by source of payment for this reporting period.

Medicare		Sliding Fee	
Medicaid		Self Pay	
Other		Total	

Is a notice posted in a conspicuous manner in your waiting room stating that a discounted sliding fee schedule is employed by your practice and that patients will be treated regardless of their ability to pay?
YES □ NO □

If no, please describe how the reduced fee schedule information is shared with your patients:
_____

_____

In the past six months how many indigent and non-insured patients have been seen by your J-1 Visa Waiver physician: _____

Of the patients seen by this physician how many were appropriately referred to your facility by the Community Health Center in your area: _____

Number of users who applied for discounted/ sliding fee eligibility: _____

Number of users who were approved for discounted/ sliding fee schedule: _____

How many patients seen did not have insurance coverage: _____

Are you still accepting new patients? □ Yes □ NO
If yes, skip the next question

If you are not accepting new indigent patients, please explain the reason:
_____

_____

J-1 Physician Certification: I hereby acknowledge that all information and statements contained herein are and do not misrepresent fact. I further acknowledge that have complied with the requirements of the Conrad 30 J-1 Visa Waiver Program.

_____ _____
J-1 Physician Signature Date

_____
J-1 Physician Name (Printed)

Employer Certification: I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have complied with the requirements of the Conrad 30 J-1 Visa Waiver Program.

_____ _____
Authorization Employer Signature Date

_____ _____
Authorization Employer Name (Printed) Title

Please mail completed report and a copy of current discounted/sliding fee schedule to David Roberts, Program/Workforce Coordinator, Division Of Public Health Services, Rural Health & Primary Care Section, 29 Hazen Drive, Concord, NH 03301-6504